

Patient Care Report

Section 1. Pre-Care Information	
Incident date (yyyy/mm/dd): ____/____/____	Incident number:
Incident address:	Incident city:
Incident state:	Area/Zip code:
Incidence location type:	
Section 2. Emergency Services	
Emergency medical dispatch performed: <input type="checkbox"/> No <input type="checkbox"/> Yes, pre-arrival by bystanders <input type="checkbox"/> Yes, on-arrival by emergency services	If yes , elaborate on medical dispatch details performed:
Chief complaint (reported by dispatch):	
Dispatch or vehicle number:	Emergency service officer name:
_____ Signature	Date (yyyy/mm/dd): ____/____/____
Section 3. Patient Information	
Last name:	First name: MI:
Date of birth (yyyy/mm/dd): ____/____/____	Age:
Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Prefer not to say	SSN:

Race:	Ethnicity:
Patient address: <input type="checkbox"/> Same as incident (skip Section 3a) <input type="checkbox"/> Other (complete Section 3a)	
Section 3a. Patient Address	
Street address:	City:
State:	Area/Zip Code:
Section 4. Patient Health Status	
Previous medical history:	
Previous medications:	
Current medications:	
Allergies (if known):	
Patient chief complaint:	
Additional notes/information:	
Section 5. Vital Signs	
Level of Consciousness (L.O.C) <ul style="list-style-type: none"> • Alert _____ • Voice _____ • Pain _____ • Unresponsive _____ 	Speech <ul style="list-style-type: none"> • Coherent _____ • Incoherent _____ • Slurred _____ • Silent _____

<p>Skin</p> <ul style="list-style-type: none"> • Normal _____ • Damp _____ • Hot _____ • Cold _____ 	<p>Colour</p> <ul style="list-style-type: none"> • Normal _____ • Cyanotic _____ • Flushed _____ • Pale _____
<p>Respiration</p> <ul style="list-style-type: none"> • _____ Normal • _____ Rales • _____ Distressed • _____ Absent 	<p>Pulse (bpm)</p> <ul style="list-style-type: none"> • _____ Normal • _____ Rapid • _____ Slow • _____ Absent
<p>Blood Pressure</p> <ul style="list-style-type: none"> • _____ Normal • _____ High • _____ Low 	<p>Additional notes/checks:</p>

Section 6. Physical Examination

Injury Present:

- Yes (go to section 6a.)
- No (skip to section 6b.)

Section 6a. Injury

<p>Cause of injury:</p>	<p>Injury Type:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Burn <input type="checkbox"/> Blunt <input type="checkbox"/> Penetration <input type="checkbox"/> Other: _____ <input type="checkbox"/> Unknown
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Additional notes:

Section 6b. Substance Use**Indicators:**

- None
- Smell of alcohol on breath
- Slurring or intoxicated behaviours
- Alcohol or drugs found on scene or on patient
- Patient admits to alcohol use
- Patient admits to drug use

Additional notes (i.e., substance details):

Section 7. Preliminary Diagnosis**Preliminary Diagnosis:**

Additional notes and procedures:

Practitioner name_____
Practitioner signature

Date (yyyy/mm/dd): ____/____/____

Section 8. Patient Diagnosis**Diagnostic procedures:**

Resources and tools used:

Results:

Diagnosis:

Medical condition(s):

- | | |
|---|---|
| <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> Head trauma |
| <input type="checkbox"/> A.M.S | <input type="checkbox"/> Hyperthermia |
| <input type="checkbox"/> Amputation | <input type="checkbox"/> Hypothermia |
| <input type="checkbox"/> Altered L.O.C | <input type="checkbox"/> MVC |
| <input type="checkbox"/> Anaphylaxis | <input type="checkbox"/> Falls |
| <input type="checkbox"/> Burns | <input type="checkbox"/> Full arrest |
| <input type="checkbox"/> Cardiac Arrest | <input type="checkbox"/> Poisoning/overdose |
| <input type="checkbox"/> Cardiac Chest pain | <input type="checkbox"/> Respiratory complaints |
| <input type="checkbox"/> Childbirth | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Congestive heart failure | <input type="checkbox"/> Shock |
| <input type="checkbox"/> Coma | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> CVA | <input type="checkbox"/> Other(s): _____ |

Additional notes:

Practitioner name

Practitioner signature

Date (yyyy/mm/dd): ____/____/____

Section 9. Patient Consultation

- **Patient grants treatment (go to section 9a)**
- **Patient refuses treatment (go to section 9b).**

Section 9a.

This is to verify the patient accepts treatment and is aware of the risks of doing so.

Patient name

Patient signature

Date (yyyy/mm/dd): ____/____/____

Witness name

Witness signature

Date (yyyy/mm/dd): ____/____/____

Section 9b.

This is to verify the patient refuses treatment and is aware of the risks of doing so.

Patient name

Patient signature

Date (yyyy/mm/dd): ____/____/____

Witness name

Witness signature

Date (yyyy/mm/dd): ____/____/____

Section 10. Treatment and Interventions

Treatment type(s):

Treatment detail(s):

Medication(s):

Treatment administrator

Signature

Date (yyyy/mm/dd): ____/____/____

Patient response(s) to treatment:

Additional notes:

Practitioner's name

Practitioner's signature

Date (yyyy/mm/dd): ____/____/____

Section 10. Summary

Patient care summary:

Medications:

Recommendations:

Follow-up: ____/____/____

Additional notes:

Practitioner's name

Practitioner's signature

Date (yyyy/mm/dd): ____/____/____